WISCONSIN MEDICAID
PRIOR AUTHORIZATION DENTAL ATTACHMENT 1 (PA/DA1) COMPLETION INSTRUCTIONS

The Wisconsin Medicaid Program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

When completing PA requests, answer all elements as thoroughly as possible. Provide enough information (check all boxes that apply) for Wisconsin Medicaid dental consultants to make a reasonable judgement about the case.

Submitting Prior Authorization Requests
Dentists may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 if X-rays or models are not required for documentation purposes. Dentists who wish to continue submitting PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

HEADER COMPLETION INSTRUCTIONS: Complete the numeric information at the top of **each** page of the Prior Authorization Dental Attachment 1 (PA/DA1). This information ensures accurate tracking of the PA/DA1 with the Prior Authorization Dental Request Form (PA/DRF) through the PA review process. This attachment will be returned to the provider if the numeric information is not completed at the top of each page submitted.

PA Number — Indicate the preprinted number stamped at the top of the PA/DRF.

Recipient's Medicaid Number — Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Billing Provider Number — Enter the eight-digit provider number. Use the billing number you will use on Medicaid claims.

Performing Provider Number (if different) — Enter the eight-digit provider number of the dentist who will actually provide the service if the performing provider is different from the billing provider.

SERVICE SECTION COMPLETION INSTRUCTIONS

Category — Select the category that describes the requested service(s).

Procedure Codes — Check the box for the appropriate procedure code(s) that represents the service(s) being requested.

Treatment Plan Justification — Check all boxes that apply for the appropriate reason(s) the procedure(s) is to be performed.

Required Documentation — This column lists the documentation that must be submitted with the PA request.

Upon completion, attach this to the PA/DRF.